X 2017-1273

PRINTED: 11/27/2017
FORM APPROVED

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 WAC Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. Onsite dates: 10/31/17 to 11/2/17 The survey was conducted by: Joyce Williams, BSN, RN Kimberly Metz, MSN, BSN, RN Lisa Mahoney, MPH, PHA The Washington Fire Protection Bureau conducted the fire life safety inspection on 10/31/2017 During the course of the survey, surveyors assessed issues related to complaint #2017-13148. The complaint was not substantiated. ASE # 9J8711	L 000		
L 200	322-030.1 DISCLOSURE STATEMENT WAC 246-322-030 Criminal history, disclosure, and background inquiries. (1) The licensee or license applicant shall require a disclosure statement as defined in RCW 43.43.834 for each prospective employee, volunteer, contractor, student, and any other individual associated with the hospital having direct contact with	L 200	L200 322-030.1 Disclosure Statement HOW: The licensee will acquire a disclosure statement as defined in RCW 43.43.834 for all prospective employees, volunteers, contractors, students, and any other individual associated with the hospital having direct contact with vulnerable adults. WHO: Director of Human Resources	

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael J Lue | TITLE: CEO | (X6) DATE: 1-18-2018

STATE FORM 6899 9J8711 If continuation sheet 1 of 15

1/18/18 Received Joyce Williams RN
Error (1/22/18 Approved Joyce Williams RN
Final Approval 5/10/18 Joyce Williams RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 1 vulnerable adults as defined under RCW 43.43.830. This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the psychiatric hospital failed to require a disclosure statement for prospective employees and contractors consistent with revised code of Washington (RCW) 43.43.834. Failure to require applicants to provide a disclosure statement pursuant to RCW 43.43.834 Child and Adult Abuse Information Act, puts patients at risk of abuse from improperly screened staff and contractors. Reference: RCW 43.43.834 Background checks by business, organization, or insurance company-Limitations-Civil liability. "(2) A business or organization shall require each applicant to disclose to the business or organization whether the applicant: (a) Has been convicted of a crime; (b) Has had findings made against him or her in any civil adjudicative proceeding as defined in RCW 43.43.830; or (c) Has both a conviction under (a) of this subsection and findings made against him or her under (b) of this subsection. Findings Included: 1. The hospital's FCRA Background Investigation Acknowledgement and Authorization Form requires prospective employees to acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and SUMMARY OF YOUR RIGHTS UNDER the FAIR CREDIT REPORTING ACT (separate document). The form requires prospective employees to authorize the psychiatric hospital to obtain	L 200	WHAT: The Human resources director or designee will be responsible for ensuring that all employees have been provided with a disclosure statement as defined in RCW 43.43.834. Audit results of compliance to this standard will be reported to Performance Improvement Committee monthly until 100 percent compliance can be obtained, and quarterly thereafter. WHEN: All corrective actions will be completed by 01-03-2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 2 "consumer reports" or "investigative consumer reports". The form fails to identify any of the elements described by RCW 43.43.834. 2. On 11/01/17 between 2:30 and 4:00 PM, Surveyor #2 reviewed 6 employee files and 3 contract employee files. All files contained the disclosure statement described in (#1) listed above. 3. At the time of the review, Surveyor #2 asked the Human Resources manager (Staff #1) if there were any additional disclosure documents provided to prospective employees or contractors. She indicated the only document was the background check authorization form identified in(#1) listed above.	L 200	**L315 322.035.1C Policies-Treatment** **Item #1: Falls** **HOW:** All Staff were educated as of 12-23-2017 to the standards outlined in the policy and procedure. The clinical educator is responsible for maintaining rosters and sign in logs to track this education and keeping the content current. An additional unit education was conducted by the unit Director regarding the significance of bed alarms, managing their functioning status and shift by shift audit of moderate to high falls risk interventions in place as of 12-23-2017 to all staff. **WHO:**Chief Nursing Officer (CNO) **WHAT:** The CNO or designee will be responsible for ensuring that fall interventions are followed. The CNO will audit patients on falls precaution to ensure that interventions are in place as required. Audit results will be reported monthly to Performance Improvement Committee and quarterly to MEC and Governing Board. Monthly audits will continue until 100 percent compliance can be maintained for a period of two consecutive months, after which a quarterly audit will be conducted. All items below 100 percent require an action plan be submitted and completed to maintain. Cascade audits 50 charts per month for the standard of care, these audits will be added to that number. **When:** All corrective actions will be completed by 01-03-2018.	
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: Item #1 Fall Precautions Based on interview, observation, record review and review of the psychiatric hospital's policy and procedure, the hospital failed to ensure staff implemented "Fall Risk" interventions as directed by hospital policy and procedure for 1 of 1 patient observed.	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 3 Failure to implement safety interventions for patients at high risk for fall puts patients at risk for injury and serious adverse events. Findings included: 1. The psychiatric hospital's policy and procedure titled, "Fall Risk Assessment and Prevention," Policy # PC.F.100 reviewed 01/17, showed that all patients will be assessed for fall risk on admission and with any change in patient condition. Patients at high risk for fall will have *interventions in place that include personal* alarms, a yellow fall risk armband, and increased monitoring. Interventions will be changed based on the Morse Fall Risk Assessment score and documented in the interdisciplinary treatment plan and on the daily nursing reassessment form. 2. On 10/31/17 at 9:30 AM, Surveyor #3 interviewed Patient #1 who had been admitted on 10/26/17 for the treatment of Bipolar Mania. Surveyor #3 observed the patient situating herself into the bed at the end of an independent transfer from the wheelchair. Surveyor #3 observed the patient had no fall wrist band, and there was no *chair alarm or bed alarm in place.* 3. On 10/31/17 at 10:02 AM, Surveyor #3 and a Registered Nurse (Staff #2) reviewed the medical record for Patient #1. The record review showed that on admission to the hospital, staff assessed the patient as a high risk for fall, related to *unsteady gait and use of a wheelchair. The "Fall* Treatment Plan" completed on 10/26/17 showed that nursing staff were to implement fall precautions that included a fall wristband, bed alarm and chair alarm. The "Nurse Daily Patient Reassessments" completed on day shift and	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 4 evening shift on 10/27/17, 10/28/17, 10/29/17, and 10/30/17 showed that the patient was a high risk for fall. 4. During an interview with Surveyor #3 at the time of the record review, Staff #2 told Surveyor #3 that the patient had removed the wrist band the previous night. The patient had been pulling at the alarm and it was causing the patient to be agitated, so the alarm was removed. Surveyor #3 and Staff #2 found no documentation in the medical record "High Risk Fall" interventions had been removed or the patients risk for fall had changed. At the time of the record review, Staff #2 stated that the patient should have been reassessed and the "Fall Treatment Plan" modified. 5. During closed medical record review, Surveyor #1 reviewed the chart of Patient #2, an 85 year old female admitted on 09/29/17 for dementia, behavior issues and anxiety. The psychiatric progress note on 10/05/17 stated that the patient had an unstable gait and stooped posture when ambulating. The patient was evaluated as being at high risk for a fall. At 4:55 AM on 10/05/17 the nursing notes stated that the patient had an unwitnessed fall. The record indicated the patient was on "Fall Precautions" and had a yellow wrist band. There was no record that a bed alarm was in place as per policy. Staff were to check the patient every 15 minutes, but the surveyor observed that there were alterations in the record between 4:30 and 5:00 AM, indicating that the patient was "lying/sitting", instead of "eyes closed, even respirations". 6. On 11/02/17 at 11:00 AM, the chart was reviewed with the Director of Nurses (Staff #3) who agreed that the record had been altered to	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 5 change the observation outcome around the time of the patient's fall. . 7. On 11/02/17 at 10:30 AM during review of the facility's Quality Program, Surveyor #1 noted that patient fall rates were an indicator that the facility leadership had chosen as a focus area. The Director of Nursing (Staff #3) stated that the patient fall rate had been identified as an outlier in their quality measures. The facility put together a task force to evaluate the fall rate and had identified that the current Fall Risk Assessment Tool (Morse) was not based on the evaluation of a psychiatric patient population. The facility is adopting a new tool for evaluating the fall risk of patients in the psychiatric setting (Wilson-Sims). The Director of Nursing stated that the task force planned to continue to monitor fall rates and determine if the Wilson-Sims Fall Assessment Tool decreased the rate of falls in the facility. . Item #2 Pain Assessment and Reassessment . Based on interview, and review of the psychiatric hospital policies and procedures, the hospital failed to ensure staff members completed and documented pain assessment, and reassessments after each pain management intervention, as directed by hospital policy for 4 of 4 patient records reviewed (Patients #1, #3, #4, and #5). . Failure to assess, treat and reassess a patient's pain places the patient at risk for a delay in treatment and may result in patient harm. . Findings included: . 1. The psychiatric hospital's policy titled, "Pain Management," Policy # PC.P.100 reviewed on	L 315	**L315 322.035.1C Policies-Treatment** **Item #2:** Pain Assessment/Reassessment **HOW:** • Staff were educated in a staff meeting for all nursing staff on/between 12.19-12.23.17. A Handout given that describes (with an example) using PIE for adequate documentation of any pain score greator than 3 or which requires interventions. All clinical staff will be educated to the importance of documenting pain assessment, reassessment, and pain management interventions. **WHO:**Chief Nursing Officer (CNO) **WHAT:** The CNO or designee will be responsible for ensuring that patients have appropriate pain assessment, reassessment, and pain management interventions. The CNO or designee will audit patients who require prn medications for pain. 50 charts will be audited monthly for this measure with a compliance goal of 100 percent. Audit results will be reported monthly to Performance Improvement Committee and quarterly to MEC and Governing Board. Monthly audits will continue until 100 percent compliance can be maintained for a period of two consecutive months, after which a quarterly audit will be conducted. Any item below 100 percent will require an action plan. **WHEN:** All corrective actions will be completed by 01-03-2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 6 01/17, showed that pain assessment includes location, intensity, duration, quality and character using appropriate scales, the patient's acceptable level of pain, effectiveness of the plan and the patient responses to pain interventions. . 2. On 10/31/17 at 9:30 AM, Surveyor #3 and a Registered Nurse (Staff #2) reviewed the medical record of Patient #1 who had been admitted on 10/26/17 for the treatment of Bipolar Mania. The review of the "Nurse Daily Patient Reassessment" form showed on 10/29/17 at 5:00 AM the patient received acetaminophen 650 mg for complaints of "general discomfort". The documented response was "effective". Surveyor #3 found no evidence the patient's pain had been assessed for intensity, duration, quality and character using appropriate scales prior to the intervention. It is unclear when the pain reassessment was completed. The Pain Assessment section of the form for day shift shows a pain rating of "0/10." The sections labelled "quality", "pattern", and "reassessment" were blank. On the same day at 7:15 PM, the patient received acetaminophen 650 mg for complaint of "back pain". At 7:45 PM the documented response was "effective". Surveyor #3 found no evidence the patients pain had been assessed for intensity, duration, quality and character using appropriate scales prior to the intervention. The Pain Assessment section of the form for evening shift shows a pain rating of "0/10." The sections labelled "quality", "pattern", and "reassessment" were blank. Surveyor #3 found no evidence a pain management plan had been developed or acceptable levels of pain had been established with the patient as directed by hospital policy. . 3. At the time of the medical review, Staff #2 confirmed the findings. When asked by the	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 7 Surveyor about reassessment time frames and how effectiveness of the intervention was determined, Staff #2 stated that reassessments were to be completed within 15 to 30 minutes and reassessment for effectiveness should include a pain rating. 4. At the time of the medical record review, the Director of Clinical Service (Staff #4) stated that reassessments were to be completed within one hour and stated that the form did not provide a space for reassessment documentation and times. 5. Review of the psychiatric hospital's policy showed that the policy failed to provide guidance on reassessment content and timeframes. 6. Similar findings were found in the medical records for patients #3, #4 and #5.	L 315		
L 710	322-100.1D INFECT CONTROL-PHYS ENVIRON WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (e) A procedure to monitor the physical environment of the hospital for situations which may contribute to the spread of infectious diseases; This Washington Administrative Code is not met as evidenced by: Based on observation and interview, the psychiatric hospital staff failed to maintain appropriate disinfectant levels in housekeeping	L 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 710	Continued From page 8 carts. Failure to maintain the levels of disinfectant solution in housekeeping carts puts patients, staff and visitors at risk of exposure to infectious organisms. Findings Included: 1. On 10/31/17 at 9:30 AM, Surveyor #2 used a chemical test strip to assess the quantity of active disinfectant in the sanitation bucket located on a housekeeping cart on Unit 4 West. The observation showed that the bucket had <100 ppm (parts per million) of concentrated disinfectant, less than the 600 ppm described by the product manufacturer. 2. On 11/2/17 between 10:00 and 10:15 AM, Surveyor #2, accompanied by the housekeeping supervisor (Staff #5), used a chemical test strip to assess the quantity of active disinfectant in the sanitation bucket located on a housekeeping cart on the 2nd floor. The observation showed that the bucket had <100 ppm of concentrated disinfectant, less than the 600 ppm described by the product manufacturer. The surveyor then used a chemical test strip to assess the concentration of disinfectant produced from the dispenser in the housekeeping closet. The indicator showed the concentration coming from the dispenser was at the correct concentration. 3. At the time of the observation listed in (#2) the surveyor asked Staff #5 if she used any test strips to periodically check the concentration of the product used in the housekeeping carts. She indicated that she did not. The concentration of product in water is dependent on water temperature and hardness, and may not stay	L 710'	**L710 3322-100.1D INFECT CONTROL-PHYS ENVIRONMENT** **HOW:** All housekeeping staff will be educated to the requirements and processes to maintain appropriate levels of disinfectant solutions as defined by the product manufacturer. **WHO:**Housekeeping Manager **WHAT:** The Housekeeping manager or designee will be responsible for ensuring that all disinfectant solutions are maintained at the appropriate levels by housekeeping staff. The housekeeping manager or desgnee will audit disinfectant solutions used for cleaning at the beginning of each shift. Audit results will be reported monthly to Performance Improvement Committee and quarterly to MEC and Governing Board. Monthly audits will continue until 100 percent compliance can be maintained for a period of two consecutive months, after which a quarterly audit will be conducted. **WHEN:** All corrective actions will be completed by 02-01-2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 985	322-150.3B EXAM ROOM-LIGHT WAC 246-322-150 Clinical facilities. The licensee shall provide: (3) One or more physical examination rooms, with or without an exterior window, equipped with: (b) Examination light; This Washington Administrative Code is not met as evidenced by: Based on observation and interview, the psychiatric hospital failed to provide a dedicated exam room containing an examination light for patient exams. Failure to have an examination room that complies with the state licensing requirement puts patients at risk from ineffective or substandard medical care. Findings included: 1. On 10/31/17 at 11:00 AM, Surveyor #2 observed a room set up for physical exams on 2 North, behind a door signed "clean utility". The room contained an exam table, locked cabinets with patient care supplies, a hand wash sink, but the room was not equipped with an exam light. 2. At the time of the observation, the facilities supervisor (Staff #6) confirmed the finding and indicated there was no other room in the building set up for physical examination	L 985	L985 322-150.3B EXAM ROOM-LIGHT HOW: An examination light will be procured and placed in the examination room located in 2 North. WHO:Director or Facilities WHAT: An examination light will be procured and placed in the examination room located in 2 North. The presence of the light will be audited through the annual bio-medical certification process. WHEN: *All corrective actions will be completed by* 01-03-2018	
L1145	322-180.1C RESTRAINT OBSERVATIONS	L1145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1145	322-180.1C RESTRAINT OBSERVATIONS Continued From page 10 WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen minutes, intervening as necessary, and recording observations and interventions in the clinical record; This Washington Administrative Code is not met as evidenced by: . Based on interview and review of medical records, the psychiatric hospital failed to monitor patients in restraints according to its policy for 2 of 3 patients reviewed (Patients #6, #7, and #8). . Failure to follow established restraint policies and procedures places patients at risk of physical and psychological harm related to inappropriate restraint/seclusion or inadequate assessments before and during restraint/seclusion episodes. . Findings included: . 1. The psychiatric hospital's policy and procedure titled, "Seclusion and Physical and Mechanical Restraint," Policy # PC.R.100 reviewed 01/17, showed that patients in restraints must have circulation checks completed every 15 minutes. . 2. The hospital's "Restraint and Seclusion Flowsheet," revised 08/22/17, showed that skin and circulation checks are to be completed every 15 minutes by a Registered Nurse.	L1145	**L1145 322-180.1C RESTRAINT OBSERVATIONS** **HOW:** A- Staff were educated in a staff meeting for all nursing staff on/between 12.19-12.23.17 to the importance of the "Restraint and Seclusion Flowsheet," and that skin and circulation checks must be completed every 15 minutes by a Registered Nurse. **WHO:** Chief Nursing Officer (CNO) **WHAT:** The CNO or designee will be responsible for ensuring that all patients place in restraint have appropriate circulation checks completed as required per policy and procedure. The CNO or designee will audit all "Restraint and Seclusion Flowsheets". Audit results will be reported monthly to Performance Improvement Committee and quarterly to MEC and Governing Board. Monthly audits will continue until 100 percent compliance can be maintained for a period of two consecutive months, after which a quarterly audit will be conducted. Each episode of restraint is audited by supervisor or Director for immediate correction of behavior/documentation. **WHEN:** All corrective actions will be completed by 01-03-2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1145	Continued From page 11 3. On 11/01/17, Surveyor #3 reviewed the medical record of Patient #7 for 5 episodes of behavioral restraint as follows: a. On 09/09/17 at 2:00 PM and released from restraint on 09/09/17 at 9:30 PM. b. On 09/11/17 at 1:00 PM and released from restraint on 09/11/17 at 5:00 PM. c. On 09/12/17 at 3:05 PM and released from restraint on 09/12/17 at 4:50 PM. d. On 09/13/17 at 9:45 AM and released from restraint on 09/13/17 at 9:45 PM. e. On 09/14/17 at 3:00 AM and released from restraint on 09/14/17 at 2:00 PM. 4. The review showed no documentation on the seclusion/restraint monitoring flowsheet to indicate that staff members assessed the patient's circulation and respiration for the following periods: a. On 09/09/17 from 2:00 PM through 2:30 PM a period of 30 minutes. b. On 09/09/17 from 2:45 PM through 4:15 PM a period of 1 hour and 30 minutes. c. On 09/09/17 from 8:30 PM through 9:30 PM a period of 1 hour. d. On 09/11/17 from 1:15 PM through 5:00 PM a period of 3 hours and 45 minutes. e. On 09/12/17 from 1:45 PM through 2:45 PM a period of 1 hour. 5. The review showed that Certified Nursing Assistants (CNAs) completed the circulation checks that were documented in the medical record. The Intervention protocol indicates that Registered Nurses should complete the checks. 6. Review of the medical record for Patient #9 showed similar findings.	L1145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1145	Continued From page 12 7. On 11/02/17 at 11:30 AM, Surveyor #3 interviewed the Chief Nursing Officer (Staff #3). She stated the psychiatric hospital was aware the current "Restraint and Seclusion Flowsheet," showed that skin and circulation checks were to be completed every 15 minutes by a Registered Nurse. She stated that the format of the form may be creating confusion related to who has responsibility. She also stated that the hospital was in the process of developing improved documentation forms and the every 15 minute circulation checks will be completed by the staff member providing the continuous in-person monitoring.	L1145		
L1425	322-210.4B MED P&P-ADVISORY GROUP WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (4) The appropriate professional staff committee shall approve all policies and procedures on drugs, after documented consultation with: (b) An advisory group comprised of representatives from the professional staff, hospital administration, and nursing services; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and review of the psychiatric hospital policies and procedures, the hospital failed to follow its policy and procedure for review and selection of emergency medications and emergency medication storage. Failure to follow established hospital policy and	L1425	**L1425 322-210.4B MED P&P-ADVISORY GROUP** **HOW:** Emergency Medications, Policy #PHR 132 will be updated to reflect the current medication storage practice and inventory. **WHO:** Pharmacist in Charge (PIC) **WHAT:** The Pharmacist in Charge (PIC) or designee will be responsible for ensuring that Policy #PHR 132 is updated to reflect the current emergency medication inventory and storage practices at Cascade Behavioral Hospital. This policy will be approved by the Medical Staff in coordination with the Pharmacy and Therapeutics Committee (P&T). **WHEN:** All corrective actions will be completed by 01-03-2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1425	Continued From page 13 procedure risks patient safety. . Findings included: . 1. The psychiatric hospital's policy and procedure titled, "Emergency Medications," Policy #PHR 132 reviewed 05/17, showed that the Medical Staff in coordination with the Pharmacy and Therapeutics Committee (P&T) must select and annually review the list of emergency medications and that these emergency medications will be stored in the automated dispensing cabinet. The list of medications approved by the P&T committee included: ammonia inhalants, Ativan injection, Benadryl injection, Epi-Pen, Glucose Oral Liquid gel, Glucagon injection, Narcan injection, and Nitrostat tablets. . 2. On 10/31/17 at 09:45 AM, Surveyor #3 inspected the contents of a portable box labelled "Emergency Medication" located in the medication room of the Gero-Psych Unit. The emergency box contained: Aspirin 81 mg (5 tablets), Diphenhydramine 25mg capsules (5 capsules), Diphenhydramine 50 mg/ml for injection (2 vials), Clonidine 0.1 mg tablet (5 tablets), Haloperidol 5mg/ml for injection (2 vials), Ventolin inhaler, Epinepherine for injection 1mg/ml (2 vials), Ammonia inhalant (2 capsules), Haldol 5mg tablets (10 tablets), Nitro Stat 0.4 mg tablets (1 bottle), Potassium 10 MEQ tablets (5 tablets), Geodin Vial with sterile water for injection (2 vials), Glucagon Emergency Kit (1 kit), Glucose Gel (1 tube), Naloxone 2mg/ml for injection (2 vials), Zyprexa 5mg/1ml with sterile water for injection (2 kits). . At the time of observation, Staff #4 stated that no medications could be removed from the automatic drug dispensing cabinet on override	L1425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1425	Continued From page 14 and this resulted in long delays in accessing medications. She stated that because of this delay, an emergency medication box containing medications that could be quickly accessed was located in each department medication room. Staff #4 provided the Surveyor #3 with a list of contents for the emergency drug box which matched the contents of the box. 3. On 11/01/17 at 11:47 AM, Surveyor #3 interviewed the Director of Pharmacy (Staff #7) related to the discrepancies between the hospital's approved "Emergency Medications" policy, the current practice for storage of emergency medications and the medications contained in the boxes. Staff #7 stated that the policy had been reviewed by the P& T Committee in May 2017, however, he was unsure why the policy did not reflect the current medication storage practice. Staff #7 told Surveyor #3 that medications are added to the emergency medication box when physicians ask for them. Surveyor #3 found no evidence the hospitals current practice for emergency medication storage had been reviewed or approved by the P&T or Medical Executive Committee as directed by hospital policy. Surveyor #3 found no evidence that the hospital's current practice had been approved by the P&T committee or the Medical Executive Committee as directed by hospital policy.	L1425		